MFMP POSTNATAL SCREENING
SUMMARY OF FEEDBACK AND RECOMMENDED RESPONSE

GENERAL FEEDBACK

OVERALL COMMENTS – FORMAT AND LENGTH

FEEDBACK	RESPONSE
▪ I have received several comments about the format of this screener. Many staff members indicated the "arrow system" is difficult to follow (this feedback is based on their experience with the use of prenatal screen that is similarly formatted). Comments were also made that the paper version in this format wastes a lot of paper.	▪ We have recently reformatted the integrated maternal screener slightly. The arrow system will be much easier to use. Also, the paper version does use much paper. However, it was intended to try to eliminate having too much information on one page.
▪ This seems to be more of an assessment than a screening tool. I like it as an assessment because it deals with the issues we can do something about rather than those we cannot (like those questions on the current assessment about cleaning supplies). If there still needs to be separate screening and assessment tools, I would suggest only a few questions that directly deal with the qualifiers for the screen.	▪ Because of this much larger screener, the assessment that is done after the screener has been shortened for the pilot sites. MFMP would defer this to the Steering Committee.
▪ The questionnaire is long—14 pages for infant—seems more like assessment or a form we fill out while we see infant. How can we screen an infant at 8-weeks and complete pages 5-14?	▪ The screener was developed to be able to catch infant information at any age when they begin services. It is not expected for case managers to complete pages 5-14 (2-10 months) if the infant begins service at 8-weeks.
▪ Maternal screen-why not incorporate into an assessment—again—very long.	▪ While utilizing the population management model, it is ideal to capture as much information on the mother and infant as possible (when you have them) so they both can receive immediate services as needed. For example, if the mother screens positive for depression, she should be immediately referred to mental health services or social worker.
▪ Is the expectation that this will take approximately 20 minutes in WIC to complete?	▪ No. Currently, we are unsure how long the infant screener will take in the WIC clinic. We currently have MIHP providers pilot testing it, so we may have a better idea how long the screener will take and how it will best fit into current WIC client flow.
▪ Will there also be an assessment to complete?	▪ Defer to Steering Committee.
▪ There are no asterisks throughout the entire screening to indicate the high risk answers. Is there a way to condense/summarize high risk indicators at the end of the screening so the staff member should not have to go through the entire document to see what level of risk the client is at?	▪ Defer to Steering Committee.
▪ A suggestion would be to focus much of the assessment on the mother, with some pertinent infant areas, sleeping, immunization, etc and to develop a tool for revisits that is age specific. Revisits should include the ages and stages, immunization, nutrition, safety, etc., as age-appropriate.	▪ Defer to Steering Committee.

OVERALL COMMENTS – REIMBURSEMENT AND VISITS

FEEDBACK	RESPONSE
▪ The Screening Tool doesn't have a date and discipline signature line for billing purposes. ▪ The end of the screener should have a space for signature/discipline and date.	▪ A place for a date and discipline signature line will be added for the final version.
▪ What will we now use to reauthorize infant visits? We currently use the risk screen to send to the primary physician to sign.	▪ Defer to Steering Committee.
▪ Is this tool to be used for both a client that did not participate in MIHP during pregnancy, and a client that did? If this client was previously an MIHP client during pregnancy, the questions are quite repetitive of the previous assessment. This is especially true if the client entered the MIHP late in her pregnancy, and just answered very similar questions 1-2 months prior. Please clarify.	▪ Yes, this tool will be used for a client that began services during pregnancy or after birth. For mothers who began services during pregnancy, much of the information in the demographic section can simply be transferred over to the infant screener. However, the other risk factors may have changed since the birth of her baby.
▪ Is there a way we could go into the original MIHP demographic screen and just update any information that has changed? It really is not productive to gather all the information again for a person who is already enrolled.	▪ Yes, you may simply transfer the demographic information from the maternal screener. However, the other risk factors may have changed since the birth of her baby.
▪ Is this tool to be used for both a newborn and an infant enrolling at a later age (such as 6 or 8 months of age)?	▪ Yes, this tool was developed to be used for infants who begin services at birth or at a later age. The appropriate Bright Futures or ASQ questions should be completed based on the infant's age at enrollment.
▪ When would you anticipate this tool first being used? Our agency would probably try and do this in the first 2 weeks postpartum.	▪ Defer to Steering Committee.
▪ I would like to see this program **REQUIRE OR STRONGLY RECOMMEND** a postpartum home visit for **all participants**. This is a crucial time for the entire family as they adapt to a new member. Mom may be depressed; she definitely needs support/encouragement/referral for her postpartum visit and contraception services; she may need breastfeeding support; baby may have health issues, such as jaundice or feeding problems- infant sleeping/positioning is always an issue; information on immunizations, infant care or sibling issues..... and on and on it goes. I feel 1-2 postpartum home visits are crucial!!!	▪ Defer to Steering Committee.
▪ One of my main concerns with this document is: we have a lot of contact interventions. Since the reimbursement for the program is per visit, how will the MIHP staff get reimbursed for making a contact? And, what does a contact mean? Telephone…visit? We need to spell out what we mean by a contact because there may be many different interpretations of this which could potentially skew the data.	▪ Defer to Steering Committee.
▪ What do you mean by sessions? Visit? (Since reimbursement is by visits).	▪ Defer to Steering Committee.

INFANT COMPONENT

BASIC INFORMATION

FEEDBACK	RESPONSE
▪ On Provider ID# - who would this be?	▪ MIHP Provider.
▪ 1.2 - There needs to be an "other" box for client's race in case they don't fall into one of the provided choices (of if they are bi-racial). ▪ 1.2 - Need to have "other for other races.	▪ Defer to Steering Committee.
▪ 1.5 - Do you require dates of birth for the other children in this question?	▪ No, date of births are not required; only age.
▪ The staff needs a place to put the NAMES and DOB of siblings if we are to check immunizations on them in MICR.	▪ Defer to Steering Committee. ▪ Is this a role for MIHP if other children not enrolled?
▪ Is there any way for the name of the health care provider/clinic to be included in the screen?	▪ The screener was developed to help providers determine appropriate services for the client so they may receive prompt interventions. It is more appropriate to collect this information on another MIHP form or one that you as a provider develops for your use, especially since providers should not be contacting the mother's health care provider until she is officially enrolled into services.
▪ On the front page can we have a box with the Medical Provider name/address/phone #? ▪ Also, under Medicaid # can we have a line for Health Plan?	▪ The screener was developed to help providers determine appropriate services for the client so they may receive prompt interventions. It is more appropriate to collect this information on another MIHP form or one that you as a provider develops for your use, especially since providers should not be contacting the mother's health care clinic until she is officially enrolled into services and gives her permission.
▪ There is no place for address and phone number on the screening tool for tracking purposes if the client refuses services.	▪ The screener was developed to help providers determine appropriate services for the client so they may receive prompt interventions. It is more appropriate to collect this information on another MIHP form or one that you as a provider develops for your use, especially since providers should not be contacting the mother's health care clinic until she is officially enrolled into services and gives her permission.
▪ The following information does not appear on the screener: - Primary care giver's name - Phone number - Current address - Directions - Employment status - Last grade completed - Language	▪ MFMP recommend entry on a face sheet and content decided at local level.
▪ Add: Who is the baby's health care provider? This should be on the front.	▪ See above.
▪ **Questions about child deaths have not been added. Would recommend addition aquestions about having children who were stillborn or who died on the Demographic Information (02/23/2006).**	

INFANT HEALTH STATUS

FEEDBACK	RESPONSE
▪ The following information does not appear on the screener: - Gestational age at birth and head circumference - Well child visit	▪ Gestitational aged added. ▪ MFMP does not recommend addition of others at this time.
▪ Is this going to be integrated with WIC also? Many of the questions on the first page come right from WIC, so that would be helpful.	▪ MFMP would recommend awaiting the completion of the pilots and using that experience to inform the “infant WIC integration” decision.
▪ Do you plan to integrate this screening tool with WIC postpartum?	▪ See above
▪ 2.2-2.3B - What if the mother/client doesn't know the birth or current weight/height of the infant? Is there a place for an "unknown" or a "refuse" response?	▪ MFMP would recommend adding an "unknown" box, but would encourage providers to determine the correct answer whenever possible.
▪ 2.5 Question - 2.5 asks a lot of information and there is no space to document the client's response.	▪ MFMP will reformat this.
▪ Rationale for adding "nighttime bottle behavior question" The bottle-feeding questions in the postnatal screening relate to the nutritional risks of Early Childhood Caries (ECC-previously known as baby bottle tooth decay) but do not address parent behaviors that contribute to ECC such as nighttime feeding practices. A 2001 survey in Michigan showed that young parents (41% vs. 18% in parents age 30-39) and Hispanics (76% vs. 27% non-Hispanics) were more likely to send their child to bed with a bottle filled with liquids other than water. Reducing such behaviors was an objective of Healthy People 2000. ECC is a significant medical condition whose hospitalization has immediate costs of $2000 to $3000 per child. ECC affects the child's growth as evident in studies that demonstrate "catch-up" growth after children with ECC are treated. ECC often leads to future dental problems that can affect nutrition, self-esteem and future employment.	▪ This needs Steering Committee discussion. MFMP would not recommend adding additional questions regarding ECC, because we see this as beyond the scope of the MIHP program. We would recommend that information on ECC be included in an informational packet/intervention.
▪ 2.1 Need to also add gestational age (34 weeks, 38 weeks, or 40 weeks). Otherwise there is no way of knowing whether the expected due date was on time, late or early, unless you flip all the way to the demographic sheet and look at the birth date. Would be much easier if we could just add gestational age question here.	▪ MFMP would recommend simply asking gestational age of baby.
▪ 2.6 Need to follow that question with an additional question: Does your baby have any other health problems that have been identified?	▪ MFMP will add “has your baby had new problems since coming home from the hospital"?
▪ 2.8 Might be better to ask about how do they discipline child when they misbehave, rather than creating some defensiveness on asking how many times have your children been spanked.	▪ Consider after pilots.
▪ This tool gets basic information on the baby at birth/admission, but after that it only focuses on growth and development. How often to do you plan on assessing immunizations, nutrition, well child care, parenting, etc?	▪ Defer to Steering Committee.

INFANT HEALTH CARE

FEEDBACK	RESPONSE
▪ This screen asks questions about health care issues identified in the hospital but neglects any health care issue that may have been assessed since discharge.	▪ See above.
▪ Minimal history on the course of the pregnancy and/or adequacy of prenatal care is included; will this be included on the "assessment"?	▪ MFMP would not recommend adding this. This information can not be used to improve infant health in the postnatal period. However, the maternal portion of the postnatal screener may uncover reasons that contributed to lack of prenatal care i.e. depression.

▪ 3.1 - Need to add a space for weeks in addition to months. (For example, a baby could have seen the health care provider at 2 weeks of age.)	▪ Will change to weeks.
▪ 3.3 - Shouldn't there be a follow-up question(s): who & especially why?	▪ Agreed
▪ 3.4 - The Guarantee of Payment letter does not apply to Healthy Kids coverage for the child. ▪ There should be the response N/A.	▪ Agreed
▪ Need to add this question: *Does your baby see a health care provider for well baby check ups? When is your next well child visit scheduled?*	▪ Needs Steering committee discussion. Is this required as screening data or is it an educational intervention that everyone gets? If this is information needed on the screening tool, then what is the intervention?

INFANT SAFETY

FEEDBACK	RESPONSE
▪ Maternal component Page 2 following 4.2 would be good to find out if they have a crib. Is it safe lead paint, slat width, firm mattress bedding etc? ▪ Need to add a question: *Do you have a crib for your baby?*	▪ Again requires Steering Committee discussion. Given the importance of this issue, MFMP would re-commend that we keep this as a short screening question and see that every woman/family gets safe sleep intervention i.e. verbal and written information. Each community needs to refer for cribs as resources allow or dictate. ▪ We do ask about cribs.
▪ 4.3 - The wording sounds funny. Maybe it could be re-worded to state, "What position do you usually put your infant in to sleep?"	▪ MFMP investigating this issue.
▪ 4.7 - It is not clear. If client answers No, it says to go to Section 5. Is that M5 or am I missing something. To go directly to M5 would eliminate a lot of important information.	▪ No to 4.7 means they do not have a gun. So, no need to collect 4.7B.
▪ 4.7B - This indicates a high-risk, but what is the staff member supposed to do with this information? What is the purpose of this question?	▪ An educational intervention.

INFANT FEEDING AND NUTRITION

FEEDBACK	RESPONSE
• Questions from Oral Health staff and Orqal Health epidemiologist: (1) In the past month, how ofter has your child goe to bed with a bottle of juice, formula, milk, or any liquid besides water? (2) At what age do you plan to first take your baby to the dentist? (3) Do you currently have any concedrns or worries about how toa care for your child's teeth?	• Questions and responses added.

GENERAL INFANT DEVELOPMENT

FEEDBACK	RESPONSE
▪ Instructions: IF CORRECTED AGE IS More than And less than … 3 weeks Use **8 weeks** instead of 2 months Keeps the language the same	▪ Correction made.
▪ When we currently do an ASQ with a family, we often leave the actual tool with the family and keep the scoring sheet for our records. Will there be any mechanism for the family to obtain this information?	▪ Yes, we are reformatting.
▪ When determining reimbursement for an Infant/Postnatal Screen, keep in mind that just doing an ASQ takes approximately 20 minutes.	▪ Medicaid issue.

▪ Doing the ASQ questions on the first meeting with a client/infant is very cumbersome. It takes time for an infant to develop trust with the care coordinator and to cooperate with the task.	▪ This is a parent lead instrument; the professional only assists as needed.
▪ ASQ Section BF0, Item #3 - Should this read "Does your baby look at you and respond to your voice?" instead of "responds"? It sounds funny. Same question for BF1 Item #3. Change "responds" to "respond."	▪ Correction made.
▪ The ages listed under each "General Infant Development" section do not correlate with the "corrected age table" in the instructions on what sections to answer.	▪ This is an educational issue for providers. Reformatting will change this as well.
▪ For the Ages and Stages. We should have the grading scale with it. We do not want to duplicate our work and fill out another scale. ▪ Is there a key for the answers to the ASQ questions? How is this scored?	▪ The scoring sheet will be provided. This will require provider education.
▪ We are NOT big fans of the ASQ tool.	▪
▪ What is the intent of this section? Does the parent just answer the questions or will this be done in conjunction with a nurse in the home or office and be combined with a clinical develop-mental evaluation? WE WOULD HIGHLY RECOMMEND THAT THIS BE CONDUCTED WITH A NURSE SIMULTANEOUSLY CONDUCTING A CLINIC DEVELOPMENTAL EVALUATION. Parents will not be able to logically answer the questions that are here. The questions are too specific. For example, question #9 on page 6 states: "When he is on his tummy, does your baby hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?" A parent would have a hard time really answering that unless a nurse could actually help the parent put the baby on his tummy and watch for the chin distance and watch the clock for the 15 seconds that is needed. Again, we would recommend that this be done in a home or office setting with a nurse and parent together.	▪ See MFMP white paper.
▪ What instructions/directions will the person administering this screen be given? If it's just to ask the parent the questions, then I continue to oppose this tool. It is too hard for a parent to admit that their baby doesn't do something when they want so much for their baby to be doing well. I believe that's why so many children get missed or "screened out" when using this tool--it's a very difficult process for parents to work through when something is wrong with their child and it takes them a long time to be able to admit there's a problem. Sometimes it's even hard for the professional to admit a baby can't do something! I could support the use of this tool if it was actually used as an assessment or screening of the baby's abilities. If a professional was assessing whether a baby holds her head up when on her tummy, brings her hands together, rolls over, turns to a voice, etc. The areas this tool tries to evaluate are good-the problem is the total dependence on the parent for the correct answer.	▪ See MFMP white paper.
▪ Page 4 Question 5: Should ask if the baby can move his arms, legs equally?	▪ See MFMP white paper.
▪ Page 5 first question: "If you copy the sounds your baby makes, does your baby repeat sounds back to you?" This is not going to happen at 2 months. This will happen at 4-10 months. Are we expecting that this will happen at 2 mos? Or are we just bringing it up for discussion?	▪ See MFMP white paper.
▪ Page 6 Question 1 and 5 are the same.	▪ See MFMP white paper.
▪ Page 6 Question 9 and 16 - Again, these questions need a clinical evaluation. A parent would have a hard time answering this.	▪ See MFMP white paper.

▪ Page 11 Question 20: "When she is on her back, does your baby try to get a toy she has dropped if she can see it?" In most developmental screening, the baby is sitting, not on their back. The child will not see the toy if they are on their back.	▪ See MFMP white paper.
▪ Page 12 Question 10: This is another question that has expectations that are early. A 12 month old would be expected to do this, not a 10 month old. What is the intent in asking this for a 10 month old? Do we want the parent to answer no?	▪ See MFMP white paper.

SOCIAL/EMOTIONAL DEVELOPMENT

FEEDBACK	RESPONSE
▪ Could we add questions that more directly assess bonding/attachment?	▪ See MFMP white paper
▪ Question 1: "When upset, can your baby calm down within a half hour?" Would this be alone or with help?	▪ See MFMP white paper
▪ Question 9: "Does your baby cry for long periods?" What does long mean?	▪ See MFMP white paper

MATERNAL COMPONENT

BASICS/DEMOGRAPHICS

FEEDBACK	RESPONSE
▪ Diminished cognitive functioning and teen parents should be identified as risk factors. ▪ There is no question about the literacy barrier. This is currently a high-risk marker on the infant screening form. ▪ There is no question about the client/mother being less than 18 years old. Again, this is on the current infant screening toll as a high risk marker.	▪ (OK) Mother's DOB is asked in the demographic section – will be used to determine whether teen parent. ▪ (POLICY) I believe that teen parents will be flagged as high risk. ▪ (SCREENER) Diminished cognitive functioning – could use questions on the current maternal part B assessment.
▪ The following information does not appear on the screener: - What month did you start prenatal care with this pregnancy? - How many prenatal visits were you able to keep for this pregnancy? - Add oral health questions that were forwarded you from me to the screener.	• Consider after pilots. • Consider after pilots. • Oral health questions added.

FAMILY PLANNING AND INTERCONCEPTUAL CARE

FEEDBACK	RESPONSE
▪ Family planning questions were not included. ▪ Did we miss it or is family planning missing? ▪ Two areas that appear to be lacking are family planning and postpartum exam for the mother. ▪ There was no question(s) regarding mother's current birth control method. ▪ Need to add questions regarding the mom's health: What is the mom's chosen method of birth control? ▪ I think there needs to be some questions about contraceptives postpartum--both where to get this service and what contraceptive options are available. ▪ Add postpartum contraceptive use question	▪ (SCREENER) **CAN'T BELIEVE** we missed family planning! I will add questions based on current use/planned method and access.
▪ Any thought given to Preconceptual Health? ▪ Some questions related to interconceptual care and education related to the mother, would also be of assistance in order to improve the mothers' health before a future pregnancy has	▪ We value the health of women interconceptually and across the lifespan, but it's not a *risk factor* for this program. We recommend that: (1) discussion of interconceptual health be incorporated in services delivered to enrolled women; and

occurred. ▪ Need to add the following questions regarding the mom's health: Did the mom attend her 6 week postpartum checkup? Who is the mom's general health care provider? What type of health care coverage does the mom have for her care after her postpartum stage?	(2) information about the importance of postpartum checkups and information about how to be a healthy mom be made available at the population level (i.e., to all women as part of post-screening information packet).

ABUSE/ABUSIVE HISTORY, ETC.

FEEDBACK	RESPONSE
▪ 1.8 Not just spank child, but spank, shake or yell at baby.	▪ YES – these are good additions. Added
▪ M2. 2.8 -What is the relevance of this question? It seems very inappropriate to follow this question up wit ha question about CPS in 2.9 and 2.10. Some people spank their children…this is not necessarily child abuse. What is the purpose for such private information? How is this information going to be used? There needs to be a "refused" option for all of these questions. ▪ Question 2.8 asks about spanking. The next question is about CPS. I feel the location and sequencing of these questions implies that a CPS referral may or will be made if you admit to spanking your child.	▪ There may be more sensitive placement for these questions – we need to think about it.
▪ 2.9A and 2.10B It takes time to build rapport with a client. Again, these questions are very intrusive and personal for just meeting a person to do the screening.	▪ We have been very impressed with the willingness of women to be forthright about many sensitive issues in the piloting of the prenatal screener. We will see over the course of pilot testing of the postnatal screener whether these items seem problematic.

SOCIAL SUPPORT

FEEDBACK	RESPONSE
▪ Define "social support" (i.e. loan you money, watch kids, shoulder to cry on, etc)	▪ This question comes after an affirmative response to the prior question – “Is there someone in your life who you can count on to help you with your baby?” – I think it’s probably clear enough in that context. I don’t recall feedback on pilots suggesting this question got confusing for anyone, but will be open to new pilot data suggesting otherwise. (Note: there is good literature on different types of social support relevant to maternal outcomes, but that is more detail than we wanted to get into in the screener – recommend inclusion of that type of question in assessment).

SMOKING

FEEDBACK	RESPONSE
▪ The amount of cigarettes the parents are smoking is not asked on the infant screener. Isn't second hand smoke a concern?	▪ We ask about maternal smoking and whether anyone else in the home smokes around the baby. We do not follow up with items about quantity because of time considerations, as we would have to assess quantity smoked by each family member who is in regular contact with the baby.
▪ 3.1 Would be good to have – I stopped smoking when I found out I was prgnant and have not started smoking again.	▪ Consider when Prenatal Screener is revised.

ALCOHOL

FEEDBACK	RESPONSE
▪ 4.3 Seems very judgmental. It is legal in Michigan for an adult to drink. It is NOT okay to drink in excess, especially around an infant. This needs to be re-worded.	▪ We will think about whether there is a more sensitive way to ask about drinking around the baby.

DRUG USE

FEEDBACK	RESPONSE
▪ 5.1 Add: Did you use drugs during your pregnancy before you knew you were pregnant?	▪ Consider when Prenatal Screener is revised.
▪ 5.3A Point arrow towards the right; point arrow toward bottom	▪ Changes made.

STRESS

FEEDBACK	RESPONSE
▪ 6.1 One of the answer options is "SNAG." What does "SNAG" mean? ▪ Also, question 6.2 seems really limited.	▪ "SNAG" is typo leftover from early pilot versions of maternal screener – will remove and check for any others!!! ▪ 6.2 – not sure what to do about this until we have a chance to analyze pilot data and determine if the item adds any value.

DEPRESSION AND MENTAL HEALTH

FEEDBACK	RESPONSE
▪ 7.1 & 7.2 seem redundant.	▪ NO. That's the PHQ-2; it's validated, performs well, and contains two conceptually different aspects of depression (dysthymia and anhedonia).
▪ Shouldn't we identify that the Depression Screen is based on the Edinburgh?	▪ YES. In fact, we need to add some fine print somewhere in ALL of the screeners citing whatever source instruments are used.
▪ After completing the Edinburgh Depression Scale, there is no guide as to determine the level of the client's depression, nor a guide as to what to do with the information once it is discovered that the client is depressed, etc.	▪ (IMPLEMENTATION) This is a question relating to how providers will be set up to deal with risk issues that are identified. We recommend that providers and/or agencies participating in the screening identify pathways for this.
▪ When would this screening be done? Timing is very important to identify PP depression. Again, I would strongly recommend a postpartum home visit.	▪ (IMPLEMENTATION/POLICY) No arguments here – but this is an MDCH question. Ideally all women enrolled in MIHP prenatally would automatically roll over for at least a visit or two (full program enrollment if ongoing risk factors are present).

ABUSE/VIOLENCE

FEEDBACK	RESPONSE
▪ AGAIN, these questions are intrusive to ask on a first encounter with a new client. What happens to this information once it goes to the state? Will it ever become a legal issue? People will not answer these questions if they don't know what will happen to their personal information.	▪ MFMP is not certain this is the case – IPV instruments have been widely used in clinical settings and when they are used do capture quite a bit of risk. However, we're not happy with the way the AAS questions seem to have performed so far with the pilot data, and want to look at this further for possible revision in the next policy cycle.
▪ Add isolation along with DV	▪ If this refers to partner-induced isolation then we believe this is captured in option 2 under 8.4.

INFANT FEEDING

FEEDBACK	RESPONSE
▪ "We think the section on infant feeding would be more appropriate on the infant screener. When we assess the baby for health and growth and development concerns, we would also look at infant nutrition. It seems misplaced in the post-partum screener.	▪ YES. The current location is ackward – will move to infant screener somewhere appropriate.
▪ The order of the breast feeding questions isn't really logical. 9.5 should be 9.4 etc.	▪ YES. This makes sense – will change.

BASIC NEEDS

FEEDBACK	RESPONSE
▪ 9.3 Any other information regarding the nutritional aide? ▪ What is a "nutritional aide"?? We currently only have a dietician, so what is this leading to or where does this information go? Is a "nutritional aide" available to our clients?	▪ I HAVE NO IDEA where this question came from, but suspect it might have snuck in from questions borrowed from WIC. Should pull unless there is going to be a clear policy in place to provide services or refer to WIC.
▪ 9.7 Include: " Karo syrup" and "honey."	▪ Consider with WIC input.
▪ 9.10B Point arrow towards the bottom.	▪ Reformatted.
▪ Include: Does y our baby spit up? If you, how many times a day? Is it a lot or does just a little dribble out of his/her mouth?	▪ Clinical issue.
▪ There was no question(s) regarding reliable transportation. ▪ You have not asked any transportation questions. These should be added back in at least the question on "Do you have reliable vehicle."	▪ We ask about transportation relative to access to health care. I agree that reliable transportation is important for women/families, and if it becomes an actionable priority in the context of screening (i.e., something that can either flag a family high-risk and/or is amenable to rapid intervention or referral) I will be happy to add. Otherwise recommend as part of a planning/assessment process with the family.
▪ There was no question(s) regarding how many times in the past year mom has moved.	▪ This is not correct. Question 9.9 asks directly about number of moves.
▪ There are no questions re: fire safety (working smoke detectors, etc)	▪ Is this a program priority or high-risk factor? Recommend that fire safety information be included in population level interventions (e.g., information packets).
▪ Are you having problems paying bills at this time?	▪ Consider after pilots.